MINUTES OF THE
BOARD OF COMMUNITY HEALTH MEETING
September 13, 2007

Members Present	**Members Absent**
Richard Holmes, Chairman	Frank Jones
Ross Mason, Vice Chairman (via phone)	
Mark Oshnock, Secretary	
Dr. Inman "Buddy" English	
Kim Gay	
Dr. Ann McKee Parker	
Richard Robinson	

The Board of Community Health held its regularly scheduled monthly meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Commissioner Rhonda Medows was present. (An Agenda and a list of Attendees are attached hereto and made official parts of these Minutes as Attachments #1 and #2).

Approval of Minutes

Chairman Holmes called the meeting to order at 10:39 a.m. The Minutes of the August 25 Meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Commissioner's Comments

Dr. Medows gave an update on the State Children's Insurance Program (SCHIP). At this point states do not have authorization or a continuing resolution. No conference committee has been appointed. She said there are 17 days left in the program. Georgia's CHIP, PeachCare, will run out of funds in the FY 2007 budget in October. She thanked members of the audience for signing the letter that was sent to the Congressional Leadership, the Georgia Delegation and President of the United States. No response has been received.

Dr. Medows said the State Health Benefit Plan (SHBP) is in the process of sending out information for members of the SHBP and the process is running smoothly. Open enrollment will begin in October, and the SHBP staff has held many town hall and consumer education meetings regarding consumer directed care products and the SHBP in general.

The Commissioner said today the board will receive a Medicaid Managed Care update from Kathy Driggers, Chief, Managed Care and Quality, and from the Care Management Organizations.

The Medicaid waiver that the Department is seeking for the Health Insurance Partnership Program is in the beginning stages of being drafted and open for input and ideas regarding the creation of this program.

Committee Reports

The Care Management Committee did not meet today.

Mark Oshnock, Chairman of the Audit Committee, reported that the Committee discussed three topics:

1. Financial Audit and Single Audit – it is ahead of the target date.
2. OPEB Resolution – will be presented to the full board.
3. Estimated payables and receivables – Estimated receivables are about $50 million, and the Department will work with and through the process with the

CMOs and providers to realize the $50 million, and systems are being reviewed and put in place to resolve the issues going forward.

Department Updates

Charemon Grant, General Counsel, began discussion on Rules 111-4-1-.10 to modify the State Health Benefit Plan. The rules were present for initial adoption at the July 11 board meeting. It is a recommendation to freeze enrollment in the Indemnity Option. Members who are currently in the Indemnity Option can continue to participate in this Option, but any other member thereafter would not be able to participate. A public hearing was held on August 30. To date the Department has not received any comments. Dr. Parker MADE a MOTION to approve State Health Benefit Plan Rules 111-4-1-.10 for final adoption. Secretary Oshnock SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the SHBP Rules 111-4-1-.10 is hereto attached and made an official part of these Minutes as Attachment # 3).

Ms. Grant presented the Certificate of Need Rules for initial adoption.

- Rule 111-2-2-.07 (Review Procedures) – clarifies the definition of emergency expenditures and the process by which the Department will approve an emergency expenditure.
- Rule 111-2-2-.09 (General Review Considerations) – Paragraph 1(m) clarifies the Department's process for assessing how the applicant will ensure quality services as measured by certain quality standards; Paragraph 4 is amended by adding a new subparagraph 9 which allows the Department to give special consideration to CON applications wherein the applicant is a hospital/physician joint venture; and Paragraph 4 is also amended by adding a new subparagraph 10 which allows the Department to give priority consideration to CON applications that lend to the provision of services that are or have been underrepresented in the proposed service area in the previous 12 months. Ms. Grant said this recommendation is aligned with the CON Commission recommendation where in there was testimony regarding underrepresented services throughout the State.
- Rule 111-2-2-.33 (Specific Review Considerations for Continuing Care Retirement Community (CCRC) Sheltered Nursing Facilities) – clarifies that a CCRC review for sheltered nursing facility beds would not be required to be reviewed under the Nursing and Intermediate Care Facilities rules.
- Rule 111-2-2-.34 (Specific Review Considerations for Traumatic Brain Injury Facilities) – the CON Commission Recommendation 13.0 supports the deregulation of Traumatic Brain Injury Facilities. The rule change defines how an applicant for a new or expanded traumatic brain injury program will demonstrate need.

Chairman Holmes asked Ms. Grant to review the flow of a rule change. Ms. Grant said the board initially adopts the rule; the Department sends the rule to the Health and Human Services Committee; the Department holds a public hearing (in this case the public hearing would be held in October); if there are no objections from the Health and Human Services Committee, the rules would come back to the board the following month for final adoption (in this case November).

Secretary Oshnock MADE a MOTION to approve for initial adoption Rules 111-2-2-.07, .09, .33 and .34 to be published for public comment. Dr. Parker SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (Copies of Rules 111-2-2-.07, .09, .33 and .34 are hereto attached and made an official part of these Minutes as Attachments, 4, 5, 6 and 7).

Carie Summers, Chief Financial Officer, presented a Resolution to address future Other Post Employment Benefit (OPEB) Liabilities for retired or future retired members of the State Health Benefit Plan. In FY 2008 the Department will receive $100 million in state funds from state agencies participating in the Plan and is earmarked to go towards the future liability of state employees that are retired today

or will retire eventually. The Department must deposit these dollars in the new OPEB Trust Fund, and through an interagency agreement with the Employees Retirement System and its Division of Investment Services, send those funds to them for long term investment. The Resolution – Establishment of State Employee Employer Contributions for Future OPEB Liabilities -does two things: allows the Department to deposit the money as it is received in the OPEB Trust Fund, and secondly it authorizes the Department to contract with the Retirement System for long term investment services. Secretary Oshnock MADE a MOTION to adopt the Resolution for the Establishment of State Employee Employer Contributions for Future OPEB Liabilities. Dr. English SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the Resolution for the Establishment of State Employee Employer Contributions for Future OPEB Liabilities is hereto attached and made an official part of these Minutes as Attachment # 8).

Before moving to the next Department Update, Georgia Families, Ms. Gay reported that she had attended the two-day meeting held by the Joint Appropriations Subcommittee on Health. She said it was interesting but confusing. Ms. Gay said the goal of Georgia Families is to manage care, control cost, while providing health care and education to members. Although the Department and CMOs give the Board statistics on how this program is working, a portion of the Subcommittee meeting was 60-70 people who testified and gave conflicting stories. Those who gave testimony were physician groups, hospital groups, and members. Ms. Gay said her questions are what is Georgia Families doing to get providers paid accurately? What is Georgia Families doing to reduce the emergency room visits? Are the providers doing what they need to do to work with the CMOs? Ms. Gay said her belief is that for Georgia Families to work is to have truth and trust and believe this initiative is a partnership.

Kathy Driggers, Chief, Managed Care and Quality, brought to the Board's attention a presentation the Department had given earlier to the Joint Appropriations Subcommittee on Health held in late August. She said that testimony focused on the Department's monitoring and oversight activities. Ms. Driggers emphasized that the activities are not future planned activities; the department moved from readiness reviews into implementation with oversight beginning immediately and the activities described in the testimony have been going on for some time. One of the things the Department will focus on in today's presentation to the Board is quality in this program.

Dr. Dev Nair, Director of Clinical Operations, Division of Managed Care and Quality, began discussion on oversight of the clinical services and quality program that the CMOs have implemented. He reviewed the managed care goals: improve the health care status of our members; establish contractual accountability for access to and quality of health care; lower cost through more effective utilization management; and budget predictability and administrative simplicity. Dr. Nair stated that many standard clinical measures are based on 12 months of claim or encounter data, and since the CMO implementation began October 2006 and a three-month claim lag, initial data on these measures are expected in early 2008. Evaluation of other states implementing managed care indicates that the first year generally is viewed as the baseline and improvement is not usually seen for three to five years. He reviewed program design and contractual requirements that were set up to improve health care status, and oversight of utilization, disease, and case management.

Dr. Nair said one of the most discussed issues at the Joint Appropriations Subcommittee hearings was emergency room (ER) utilization both in terms of payment issues and utilization. All three CMOs have programs in place to address appropriate or inappropriate use of the ER. DCH has required that all CMOs implement a performance improvement activity to reduce ER use which may include gathering data, analyzing data, meeting with stakeholders to assess the problem, the root causes, and barriers of members going to other sources of care. Based on that analysis the CMOs are expected to set up interventions designed to address those barriers. Interventions may include: identification of high utilizers for on-going case

management, member outreach and case management (identification of barriers, member education, nurse lines), pharmacy lock-in program, and network development.

Dr. Parker said that while she appreciates the need for various meetings and data analysis, it would appear that other states have implemented managed care and lessons have been learned; how long will the going back and forth take place before someone says this is what needs to be done. Ms. Gay asked when will this be an expected requirement. Dr. Nair said to he wanted to clarify that he was speaking of the process for performance improvements project, however all three CMOS have implemented activities to address ER utilization. Dr. Parker said she was impatient with the process since for years Medicaid has had the data about ER utilization.

Dr. Medows said the CMOs could speak to some of the efforts that they put in identifying high risk or individuals with chronic and multiple co-morbidities. They actually did some of this work at the onset. The work of identifying high utilizers of the ER is an ongoing process.

Mr. Oshnock asked what is the ER utilization. Dr. Nair answered that it is about 640-650 visits per 1000 members. Mr. Oshnock asked what is the goal. Dr. Nair said one of the difficulties of comparing with other states is looking at a specific population. When you look at other states' managed Medicaid programs they typically have different populations enrolled, so the expectation for Georgia's membership which includes primarily AFDC or TANF membership would be different than a state that might include some ABD population. Ms. Driggers added ER utilization in the Medicaid population may never be low as ER utilization in a commercial population. She said Georgia Families did its homework before beginning the program, compared ER utilization in Georgia to other states with managed Medicaid program. It is certainly lower than ours; none of it was ever as low as benchmarks that were available for commercial health plans.

Dr. Nair reviewed the contractual requirements for quality improvement: each CMO must have a quality assessment performance improvement program that monitors clinical care and service; achieve accreditation by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) within three years; and conduct eight annual performance improvement projects. Of the performance improvement projects, five of the eight have to be clinically focused and three are non-clinical performance improvement activities.

Dr. Nair talked about measurement. DCH will utilize data provided by the CMOs as well as analysis of encounter data as it becomes available. Standard measures will be utilized to the extent possible to allow for comparisons with national data or regional data. DCH will also rely on utilization data as proxy for clinical measures, preventive health and access to care indicators, and provision of clinical care. A list of performance measures is included in his presentation. (A copy of Managed Care – Clinical and Quality Monitoring is hereto attached a made an official part of these Minutes as Attachment # 9).

Dr. Nair introduced Gary Jackson of the Centers for Medicare and Medicaid Services (CMS) and Alix Love of the National Committee for Quality Assurance (NCQA) to give a national perspective and experiences of other states. Mr. Jackson is the External Quality Review Organization Quality Strategy Coordinator for CMS. Ms. Alix Love, Public Policy Manager for NCQA, is responsible for managing state and federal recognition of NCQA's evaluation program and performance measures. She works with a variety of state agencies to assist in health plan oversight and quality improvement. She also manages NCQA's public sector advisory council.

Mr. Jackson said one question he was asked to address today is what CMS expects of Georgia's Medicaid managed care program. Mr. Jackson stated that it is important to realize that nearly 65 percent or two-thirds of the Medicaid population is in Medicaid managed care. According to CMS, nearly $50 billion is going to managed care organizations. Each state must have an original/updated quality strategy on file

at CMS. CMS must approve and review the original document and any changes in the Strategy. There are mandated sections within the Quality Strategy that relate to access to care, structure and operations, quality measurement and improvement and monitoring measures. Most state Medicaid agencies competitively bid for an External Quality Review contract. CMS provides 75% enhanced match for all EQRO approved activities: validate performance improvement projects undertaken the previous year; validate performance measures undertaken the previous year; and conduct a compliance review of standards related to access, structure and operations, and measurement and improvement standards. There are five non-mandatory EQR activities that CMS will provide 75% enhanced match. The Healthcare Effectiveness Data an Information Set (HEDIS) methodology is typically used for performance measures. There are 70 measures across 8 domains of care.

Mr. Jackson talked about managed care perceptions. Mr. Jackson stated that managed care can be an ally in obtaining affordable, effective health care for Georgia citizens. He said one perception is that MCOs are a faceless large corporation and fee-for-service practice is an ideal of medical practice. Mr. Jackson stated that he thinks most MCOs work very hard to connect their patients with a personal medical home. Another perception of managed care is that it has poor quality controls. He said he thinks this is a myth and that most MCOs invented modern systems of quality management. Mr. Jackson said the flip side of the notion of poor quality, is a notion that managed care is an overnight fix for whatever ails the health care system. He said managed care should be considered as a long-term investment in the health of members, and the savings will come eventually. Managed care saves money by preventing acute care episodes, and over time patients that are well managed clinically do not end up in the emergency rooms and hospitals. He reiterated that two-thirds of the Medicaid population is in managed care, this is the direction in which Medicaid is going, and he thinks there is an obligation in part of the provider community and patients to do their best to make it work because this is the future. Mr. Jackson concluded his remarks after addressing questions from the Board. (A copy of Quality in Managed Care Strategies, Performance Improvement, and External Quality Review is hereto attached and made an official part of these Minutes as Attachment # 10).

Next, Ms. Love gave an introduction to the NCQA and key principles for quality in health care. NCQA is an independent non-profit health care quality oversight organization with a mission to improve health care quality through quality measurement, transparency and accountability by measuring and reporting health care quality. NCQA provides quality measures, accreditation, certification, and recognition of health plans, physicians and physician groups, and health care organizations; public reporting in publications such as *State of Health Care Quality* and *America's Best Health Plans,* and a consumer friendly web based report card; and research such as predictors of high-quality care for potential future measures and cultural disparities in health care. Over 76.5 million patients are impacted through the plans NCQA accredits. Thirty-eight states use or recognize NCQA. Thirty-two states collect/require HEDIS (Healthcare Effectiveness Data Information Set) measures. Ms. Love reviewed the accreditation process. The components of the health plan accreditation are HEDIS (evaluation of clinical performance), CAHPS (Consumer Assessment of Healthcare Providers and Systems), and Standards (review of key systems and processes of the health care plan). The Accreditation Process is 1. Plan self-evaluation submitted via survey tool; 2. Eight-week off-site review by NCQA surveyors; 3. Two-day on-site review by NCQA surveyors; 4. Preliminary report issued; 5. Addition of HEDIS.CAHPS scores; 6. Final status decision rendered; and 7. Points re-scored annually with HEDIS/CAHPS results. Ms. Love also gave an overview of NCQA quality improvement standards, such as quality improvement program structure and operations, availability of practitioners, complex case management, disease management and continuity and coordination of care. In the future NCQA is working to improve Medicaid strategy, field testing HEDIS measures for obesity measurement, a more robust standardized pediatric quality measures, more results from cost of care measures, and patient centered medical homes. (A copy of the NCQA presentation is hereto attached and made an official part of these Minutes as Attachment # 11).

Mr. Oshnock asked how does the accreditation relate to Georgia's current CMOs. Ms. Love said her understanding is that the three CMOs in Georgia will be looking to get new health plan accreditation in 2009 that may have been a requirement in the contract. Ms. Driggers said the CMOs are accredited in other states and are contractually required to become accredited within three years of operations. Ms. Driggers said one of the reasons the Department wanted the Board to hear from these quality experts is to understand that the performance of these plans in this state are not only being monitored by the Department, but they will also be monitored by NCQA in order for them to obtain the accreditation to which they are obligated and if they do not obtain it they are in breach of their contract as well as by CMS. She said it was important for the Board to hear from these two organizations about the scrutiny that will be given to the plans as well as the work that they are doing to improve health care outcomes.

Ms. Driggers said DCH is bringing in a well respected third-party vendor to perform a claims payment audit on all three plans. The Department signed an agreement with Myers and Stauffer last week and are in the planning stages of the scope. Myers and Stauffer will be meeting with the CMOs and various provider organizations to hear directly from provider organizations what their concerns are. Myers and Stauffer will be looking specifically at Children's Healthcare of Atlanta and will analyze and evaluate CHOA's claims payment concerns. They will also evaluate claims payments concerns expressed by the hospital community regarding problems they are reporting. Myers and Stauffer will analyze policies and procedures of the CMOs including how they contract, how they pay their providers in accordance with those contracts, their medical management policies, their approach to addressing provider concerns and how all of those policies and procedures compare to managed care industry standards. The initial phase will address concerns expressed by the hospital industry, but the Department also will have them meet with and focus on concerns expressed by physicians and other providers.

Ms. Driggers said at the two-day joint subcommittee meeting, there were questions asked at the public hearing about administrative expenses, administrative expenses of the plans as compared to administrative expenses of the Department. She said to put this in to context, the Department has moved over 900,000 Medicaid members from fee-for-service program to managed care realizing from that move over $240 million in savings annually. Rather than making fee-for-service payments directly to providers, DCH makes a monthly premium to the CMOs that is actuarially calculated and covers the medical costs, the administrative costs, and a reasonable profit margin for the plans. As shown by this considerable amount of savings, the investment of a portion of that capitation payment into the administration of the managed care program for such services that the plans provide such as utilization management, care coordination and health cost containment result in a significant return on investment for the Department. By including administrative costs into the CMO premium, 63% of the cost is paid by the federal government. The federal match would be 50/50 if this infrastructure was built into the agency.

Ms. Driggers said as Ms. Gay noted there were a lot of comments made at the two-day meeting and she wanted to review some of those and give DCH's response to those comments.

- *CMOs are not paying a significant percentage of claims in accordance with the provider contracts they have negotiated.* Ms. Driggers said she has yet to receive concrete evidence of this allegation, but payment compliance with contract terms is one of the highest priorities for the Myers and Stauffer audit. The CMOs are not obligated to replicate Medicaid policy nor reimbursement rates; however, in some situations where CMOs have told providers or contractually agreed with providers that they are going to do that, there have been some situations where there is confusion on the interpretation and nuances of our policies. DCH continues to work with the CMOs on the correct interpretation of DCH policy.
- *CMOs are failing to comply with contractual and statutory requirements to pay emergency room (ER) claims in accordance with federal "Prudent Layperson"*

standard. Ms. Driggers said there has been a great deal of comments from hospitals about the CMOs "failure to comply with contractual and statutory requirements to pay ER claims in accordance with a federal 'Prudent Layperson' standard." Based on the Department's review to date, none of the three CMOs is in violation of either the contract with DCH or the Code of Federal Regulations which deals with a Medicaid member's right to emergency and post-stabilization services. She said there is no question that there is a huge amount of ER utilization by Medicaid members for situations better treated in physician offices. This is a behavior that has been learned over time, particularly since the passage of Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986. All three CMOs currently have strategies in place to reduce the use of the ER for non-emergent care. Ms. Driggers defined EMTALA and Prudent Layperson standard. It is up to the Managed Care plan to decide who is a Prudent Layperson and whether this hypothetical reasonable person would think the actual patient's symptoms constituted an emergency. In the past DCH has been very broad in its interpretation and payment for ER services. DCH Program Integrity is currently studying Fee-for-Service ER claims from FY 06 to determine appropriate payment. This will be used to reconsider DCH ER payment practices.

- *There is no evidence that the CMOs are committing sufficient resources to actively manage the care of their enrollees. It is also unclear how the effectiveness of the CMOs case management activities is being evaluated and measured.* Ms. Driggers said each CMO has devoted considerable resources to managing members' care including member services and outreach representatives, 24-hour nurse help lines, case and disease management staff. The resources were not available to members prior to managed care.

A discussion ensued about incentives, performance measures and contractual requirements. Ms. Driggers agreed to report to the Board in December incentives, performance guarantees and liquidated damages that are already in place. Dr. Medows emphasized that there are performance guarantees as well as the ability to assess liquidated damages for very specific functions. She said what Ms. Driggers is talking about is then building on top of that an incentive program if the CMO achieved an improvement in health behavior or clinical outcome. Chairman Holmes asked Ms. Driggers to place in the October board packet a brief narrative about this discussion.

Ms. Driggers returned to the list of concerns mentioned at public hearing.

- *All three CMOs failed to properly load numerous providers into their systems, in many cases even one year after contracts were signed.* The Department does not see evidence of large scale improper load of providers. DCH asked Myers and Stauffer to evaluate timeliness and accuracy of provider credentialing and loading processes of each CMO.
- *All three of the CMOs have failed to comply with a particular section of the contract which requires the CMOs web sites to be "functionally equivalent to the web site maintained by the state's Medicaid fiscal agent."* DCH monitors and determines the compliance of the CMOs with all contract terms and conditions and consider all CMO web portals compliant with contractual requirements.
- *The CMOs often fail to comply with a section of the CMO contract which sets forth requirements related to the timely filing of claims by denying claims when the CMO, rather than the provider, was responsible for the filing error.* Ms. Driggers said DCH has been presented with no evidence of this allegation. All three CMOs have stated that they have either paid a claim incorrectly or denied it due to their error, they will pay the provider interest on the claim. DCH has asked the CMOs to report to DCH any claims that they have paid interest on since the beginning of the program.
- *Hospitals and other providers are routinely denied payments for medically necessary services because of situations beyond the provider's control.* All the CMOs have indicated that prior authorization can be updated if a clinician decides to make a change either right before or during the procedure. Mr. Oshnock said this issue has been the biggest complaint. He says he hears

from multiple parties each week on this issue. Ms. Driggers said specific instances are spoken about, but she has not been presented with specific examples to be given to Myers and Stauffer.

- *CMO representatives often reference policies and procedures that contradict specific contract terms.* There have been circumstances in which provider representatives have been unfamiliar with Medicaid in general and have misquoted or misstated DCH policy. The Department gives feedback to the CMOs when DCH know of these situations and expect that they educate their provider representatives.
- *CMOs' systems and configuration inaccuracies often result in denial of payment or reduced payments to providers.* The Myers and Stauffer audit will examine the allegation.
- *CMOs too often fail to credential providers in a timely manner and to load provider information accurately.* The Myers and Stauffer audit will examine the allegation.
- *Some CMOs are basing hospital claims submission timeliness or admission date, not discharge date.* The CMOs are not required to follow DCH policy. Specific procedures for filing claims are outlined in CMO provider manuals. However, all three CMOs have stated it is their policy to use date of discharge.
- *Patients can and do change CMOs during an inpatient stay which raises many payment issues. Standard rules should be developed to ensure that providers receive payment for medically necessary services.* Standard rules for payment of hospital patient stays during which a member moves from CMO to CMO, or FFS to CMO or vice versa, have been developed and implemented for more than a year. Newborns are automatically enrolled from birth into the CMO of the head of household (usually the Mother). The mother has 90 days from the baby's date of birth to choose a different CMO for the baby if she so desires.
- *Local CMO representatives are not empowered to resolve issues; decisions made at a corporate level may not take into consideration unique local situations and/or factors.* Ms. Driggers said each CMO has corporate policies which provide its structure; however, there is acknowledgement from the top down that all health care is local. All CMOs have revised many of their policies in order to adapt to the Georgia market.

In closing, Ms. Driggers reminded the board that over 900,000 Medicaid members were moved from a FFS model to managed care over a 120-day period in 2006. Operational issues on the part of both the CMOs and DCH were anticipated and resources were dedicated to a sustained resolution of those. Substantiated complaints are always investigated; however, many of the allegations made by providers are anecdotal without solid evidence. When DCH has been presented evidence of errors or issues with policy, DCH staff has worked diligently with the CMOs to investigate and resolve the matter. Ms. Driggers said Georgia Families is 100% committed to ensuring that Georgia Families members have access to the most appropriate health care in the most appropriate setting with optimal quality outcomes. Ms. Driggers concluded her oversight report after she and Jared Duzan of Myers and Stauffer addressed questions from the board regarding the scope of the Myers and Stauffer audit. (A copy of the DCH Response to Provider Perspectives memo is hereto attached and made an official part of these Minutes as Attachment # 12).

Michael Cotton, COO of WellCare of Georgia, began his Care Management Program Review. He gave an overview of WellCare's Georgia Operations statewide, their medical management partnership approach and WellCare's emergency room management component. WellCare receives daily ER reports from about 14 hospitals and WellCare ER nurses outreach to members within 1-2 days of receipt of the ER report for care coordination. He reviewed the ER Management care coordination and ER payment methodology (Prudent Lay Person Methodology). Mr. Cotton reviewed WellCare's quality focus—continuity and coordination of care, patient safety, Health Check/EPSDT Screenings, disease management programs (asthma, diabetes, lead screening), immunizations, and community engagement. He

said from a member satisfaction perspective the initial reviews of the member survey were favorable but there were opportunities for improvement particularly in the area of pediatric sub-specialties. According to Mr. Cotton the total claims processing turnaround time is 18.62 days and the percentage of authorizations handled in less than two days is 90%. Some of the opportunities for improvement that WellCare considers prevalent are provider billing (using single Medicaid ID for multiple locations), imaging/diagnostic services coding, CPT Code and Modifier Usage/Correct Coding, appropriateness of level of care, level and scope of services billed, therapy service volume, psycho-pharmacological drugs usage, and provider charges. Mr. Cotton said in summary, on-going actions are focused efforts on provider education and opportunities for partnership, increased focus on member outcomes and process improvements, use of data and evidenced-base protocols to improve quality, and increased access to critical sub-specialties particularly in pediatrics and the southern portion of Georgia. Mr. Oshnock asked when WCG's web portal will be compliant. Mr. Cotton said he is looking to have it up before the end of the year. (A copy of WellCare of Georgia Care Management Program Review is hereto attached and made an official part of these Minutes as Attachment # 13).

Ms. Driggers introduced Christopher Bowers, Interim President and CEO of Peach State Health Plan. Mr. Bowers reviewed the state's goals and Peach State's goals. He said access to care was a hot topic at the Joint Appropriations Health Subcommittee meeting. He stated that Peach State's Primary Care Physician to member ratio is higher than the industry standard; it conducts ongoing surveys of its physicians to confirm appointment availability within its network; and initiated specialist surveys to look at appointment availability. Mr. Bowers said Peach State is committed to ensuring access to quality dental care and exceeds the DCH geo-access requirement and has more than 900 dentists in its network. Key focus areas in Quality Care and Appropriate Utilization are: EPSDT Health Check Screens, Immunizations in children less than 35 months, blood lead level checks, chronic kidney disease, improved access for initial visit of pregnant members, emergency department usage and NCQA. The Emergency Department (ED) Management Program goals are to reduce inappropriate utilization, influence member behavior, and move patients to more appropriate level of care. Peach State has an Enhanced Emergency Department Management Program Quality Improvement Initiative and partners with hospitals to obtain daily lists of Peach State members who were seen in the ED. All hospitals have contractually agreed to an automated payment process for ED claims. Overall 68% paid at a higher rate (true emergency); 32% paid at a lower rate (Triage rate). Mr. Bowers gave a status of provider credentialing and contract loading. He said Peach State is reviewing its process to see if they can cut out time in this particular process, but he emphasized that they need full and accurate information from the provider to load them properly. Mr. Bowers briefly described the Medical Management Department and discussed the Disease Management Program, He shared with the Board member satisfaction survey results and described member programs. Mr. Bowers reported that the turn-around-claims processing time within 15 business days is 97%. Peach State received a sanction notification following a routine audit of its prior authorization process. Peach State is appealing the dollar amount of the sanction issued by DCH. Finally, he described Peach State's Fraud and Abuse initiatives. After addressing questions from the Board, Mr. Bowers concluded his report. (A copy of the Peach State Health Plan presentation is hereto attached and made a part of these Minutes as Attachment # 14.)

Ms. Driggers said she needed to make a correction on something she said. She said while most of the information she's received has been anecdotal, she has been provided with specific examples of claims payment errors by Mr. Jimmy Lewis of HomeTown Health. These examples will be utilized as part of the claims audit.

Mr. Craig Bass, CEO of Amerigroup Community Care, said his presentation was very similar to WellCare's and Peach State's. He said Amerigroup does a lot of the same activities as the other CMOs and has similar objectives and that is to be a partner with the State to improve the health care outcomes of Medicaid and SCHIP members. Mr. Bass said Amerigroup's overview would center on Obstetrics, Emergency Room Management, member satisfaction and provider satisfaction

He introduced Dr. Vergena Clark, Chief Medical Officer, who leads the medical management team which is responsible for improving the health care outcomes of the members. She reviewed Amerigroup's disease management program and Amerigroup's use of an Integrated Care Management approach which encompasses physical, mental and social needs of the members when assessing the health care needs. She gave an overview of the Obstetrical and Delivery Services and OB case management. Emergency Room (ER) Management Activities include a 24/7 nurse help line, partnership with hospital ERs to identify frequent users, educating members about after hours care, and identifying members needing case management. Mr. Bass said while visits to an emergency room have decreased in three quarters, and visits to a family doctor have increased, the cost of an ER visit has increased in three quarters. Reasons for the increase in ER visit costs include upcoding of ER levels by hospitals, charge master or price list increases by hospitals and more services charged per visit. Ms. Bass said a lot of the legislative subcommittee meeting testimony concerned therapies. He said Amerigroup believes therapy services are an essential part of an integrated health care delivery system. Compared to other markets Amerigroup serves, that percentage of the network that therapists contribute to is much greater than what Amerigroup experiences in other markets. Several reasons for therapy denials are inadequate clinical information to support medical necessity, requested service is educational in nature and not medical, and multiple requests for services. Dr. Clark said DCH is working with the CMOs to develop common medical necessity criteria as well as develop common denial language. Mr. Bass said Amerigroup hired an independent company to conduct a member satisfaction survey. He said members seem to be satisfied but providers are not as satisfied. Most issues center around claims processing. Mr. Bass reviewed the provider satisfaction survey summary and issues providers would like Amerigroup to review. This concluded the CMO First Year Analysis. (A copy of the Amerigroup Community Care presentation is hereto attached and made an official part of these Minutes as Attachment # 15).

Mr. Oshnock asked about the status of the Department's provider satisfaction survey. He said he would like to see the results.

Closing Comments

Mr. Holmes thanked Ms. Driggers and all the participants for presenting on managed care and quality.

Adjournment

There being no further business to be brought before the Board, Mr. Holmes adjourned the meeting at 2:49 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____ DAY OF

_____, 2007.

_____
RICHARD L. HOLMES
Chairman

ATTEST TO:

_____
MARK D. OSHNOCK
Secretary

Official Attachments:

#1 List of Attendees
#2 Agenda
#3 SHBP Rules 111-4-1-.10
#4 CON Rules 111-2-2-.07
#5 CON Rules 111-2-2-.09
#6 CON Rules 111-2-2-.33
#7 CON Rules 111-2-2-.34
#8 Resolution for the Establishment of State Employee Employer Contributions for Future OPEB Liabilities
#9 Managed Care – Clinical and Quality Monitoring Presentation
#10 CMS Quality in Managed Care Strategies, Performance Improvement, and External Quality Review Presentation
#11 NCQA presentation
#12 DCH Response to Provider Perspectives Memo
#13 WellCare of Georgia Care Management Program Review
#14 Peach State Health Plan Presentation
#15 Amerigroup Community Care Presentation